SAMPLE

Mental Retardation Community Medicaid Services

____ **NEW**
FOR CSP YEAR

____ **REVISION**
FOR CSP YEAR

Consumer-Directed PERSONAL ASSISTANCE

INDIVIDUAL SERVICE PLAN

Individual: _____ Medicaid Number: _____

Services Facilitator/Agency: _____ SF Provider Number: _____

Services Facilitator Telephone Number: _____ Services Facilitation Start Date: _____

Designated Backup: _____ Telephone: _____

ISP Start Date: _____ Quarterly Review Dates: _____ _____ _____ _____

SUPPORT GOAL/ OUTCOME: *To be as independent as possible in my home and community*

PURPOSE OF SUPPORT *(Examples in italics.)*	WHEN SUPPORT IS PROVIDED	HOW AND WHERE SUPPORT WILL BE PROVIDED *(Examples in italics.)*
1. To get ready for work	*Work day mornings (M – F) from 7-9 am*	*In my home, my assistant will help me bathe and dress, prepare and eat breakfast, pack a lunch and catch the bus.*
2. To be involved in the community	*Tues 6 - 9 pm; Sat 1 – 5 pm; Sun 10am – 1pm*	*My assistant will help me schedule and accompany me to places and activities in the community, such as my bowling league, shopping, church, restaurants, visiting friends, and other activities that arise. He will help me with my personal needs, assist me in scheduling and using Medicaid Taxi, eating, and getting around safely.*

TOTAL HRS PER WEEK:_____		